



OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER
Commissioner of Insurance Industrial Loan Commissioner Safety Fire Commissioner Comptroller General

2 MARTIN LUTHER KING, JR., DRIVE, SUITE 708, WEST TOWER, ATLANTA, GA 30334
Phone: 404-656-7556 Fax: 770-344-5798 Email: TBrewster@ocl.ga.gov

www.ocl.ga.gov

Application For Pharmacy Benefits Managers

FORM
GID-256-EN
Rev. JAN11

Application is hereby made for a License to operate as a Pharmacy Benefits Manager pursuant to the Laws of Georgia. In addition to the completed forms, please provide a check or money order for \$500.00 made payable to the Georgia Department of Insurance to the attention of Tammy L. Brewster, Financial Analyst, Enforcement Division.

ADDRESS TO REMIT BY MAIL:

Georgia Dept. of Insurance-Regulatory Services/Enforcement, P.O. Box 935138, Atlanta, GA 31193-5138

ADDRESS TO REMIT BY COURIER:

Wachovia Bank, Georgia Dept. of Insurance-Regulatory Services/Enforcement, Lockbox 935138, 3585 Atlanta Ave, Hapeville, GA 30354

In support thereof, the following information and documentary evidence is submitted:

Date Filing: _____ FEIN: _____

Name of Organization: _____

Mailing Address: _____

Street Address: _____

Office Building: _____

City: _____ County: _____

State: _____ Zip: _____

Telephone Number: (____) _____ Fax Number: (____) _____

Email Address: _____

Name of Attorney or Principal filing this application:

Mailing Address: _____

Street Address: _____

City: _____ State: _____

Telephone Number : (____) _____ Fax Number: (____) _____

Email Address: _____



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NOTE: ANSWER THE FOLLOWING QUESTIONS AND PROVIDE THE INFORMATION REQUESTED ON SEPARATE SHEETS IDENTIFYING EACH BY THE CORRESPONDING NUMBER ON THIS APPLICATION.

- (1) A financial statement of the two most recent years that demonstrates that the applicant possesses a minimum net worth of \$200,000. Letters of credit, backstop guarantees and special corporate structures will not be taken into consideration by the Commissioner in determining the net worth requirement.
- (2) Every pharmacy benefits manager shall file a bond with the Commissioner. The pharmacy benefits manager shall file a certificate of such bond, in a form acceptable by a corporate surety insurer authorized to transact insurance in this state in favor of Commissioner of Insurance of the state of Georgia, continuous in form and in an amount \$100,000.
- (3) The bond shall inure to the benefit of any person damaged by any fraudulent act or conduct of the pharmacy benefits manager and must be conditioned upon faithful accounting and application of all money coming into the pharmacy benefits manager's possession in connection with its activities as an pharmacy benefits manager.
- (4) The bond remains in force until released by the Commissioner or canceled by the surety. Without prejudice to any liability previously incurred, the surety may cancel the bond upon thirty (30) days' advance notice to the pharmacy benefits manager and the Commissioner. A pharmacy benefits manager's license shall be suspended if it does not file with the Commissioner a replacement bond before the date of cancellation of the previous bond. A replacement bond must meet all requirements of this section for the initial bond.
- (5) Each pharmacy benefits manager shall obtain errors and omissions coverage or other appropriate liability insurance, written by an insurer authorized to transact insurance in this state, in an amount of at least \$250,000.
- (6) Any policy written in accordance with paragraph 5 shall be for a term of at least one year and shall contain provisions that:
 - (a) Cancellation or termination of the policy is not effective except upon sixty (60) days' written notice by registered or certified mail to the other party to the policy and to the Commissioner; and
 - (b) The policy is automatically renewable at the expiration of the policy period except upon sixty (60) days' written notice by registered or certified mail by the party not renewing the policy to the other party to the policy and to the Commissioner.

FOLLOWING ATTESTATION SHALL BE USED

I do solemnly swear or affirm that I am familiar with the Laws of Georgia relating, to Pharmacy Benefits Managers; that all the foregoing information and documentary evidence submitted is true, complete and correct to the best of my knowledge and belief.

Company _____

Sworn to and Subscribed before Me

Signature _____

this ____ day of _____,

Print Name _____

Print Title _____

(SEAL)